Left Hand Community Acupuncture

Pediatric Intake Form

All Medical Information is confidential.

I. General Information.

Name of Child: ____ Date: ________________________

Name of Parent(s)/Legal Guardian(s): ____

Occupation(s): ____

Parents are (circle): Married Separated Divorced Living Together Other: _____________

Address: ____ City/Zip: _____________________

Phone: (home) _____________________ (cell) ___________________ (work) ____________________

Email: ____

Child's Date of Birth: ______________ Age: ___________ Height: ___________ Weight: ____________

Sex (m/f): _________ Grade of School: ________________

Child's Primary Care Provider/Contact Information: ____

Emergency contact name & phone number: ____

How did you hear about us? ____

Reasons for your visit: (1)

(2)

(3)

What initiates the symptoms? ____

What makes them better? _____________________What makes them worse? ____________________

II. Medical History

Previous Medical History.

YES (Y) indicates the child gets the problem regularly; **NO (N)** indicates the child never had the problem; **PAST (P)** indicates the child had the problem in the past but not recently. Please circle the correct answers for your child.

Ear Infections: Y N P If has had, how many total: _________________
Colds: Y N P If has had, how many total: _________________
Strep Throat: Y N P If has had, how many total: _________________

How many times has the child taken antibiotics: ____

Hearing tests normal: Y N Not tested
Vision tests normal: Y N Not tested

Speech impediments: Y N Not tested
Learning impediments: Y N Not tested

Vaccination History.
Please circle all applicable vaccinations.

MMR Age: ___________
HepB Age: ___________
DPT Age: ___________

Chicken Pox Age: ___________
Polio Age: ___________
Hib Age: ___________

Flu Age: ___________
MCV Age: ___________
HPV Age: ___________

Others: ____

Please note any adverse reactions to vaccinations: ______________________________________

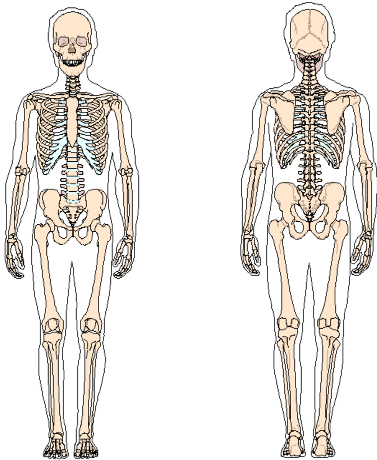
System Overview.
Please circle all that apply.

Jaundice as baby
Cradle cap
Eczema/Psoriasis
Colic
Chronic sniffles
Allergies
Asthma
Very sweaty
Diaper rash

Diarrhea
Constipation
Finicky eating
Stomach aches
Anemia
Autism
Growing pains
Poor teeth
Fears/phobias

Hyperactivity
Nightmares
Bed wetting
Tantrums
Epilepsy/Seizures
Depression
Early puberty
Disobedient
Diabetes

Others:____



Musculoskeltal Overview
Please indicate any areas of pain in the body on the diagram at the left.

What makes the pain better/worse?
____
____
____
____

Medication/Supplements.

List ALL medications (from the drugstore and/or prescription) your child is on now:
____
____
____

List all supplements/vitamins your child is on now:
____
____
____

Allergies.

Is your child allergic or hypersensitive to any:

Drugs? ____

Foods? ____

Animals? ____

Environmental Factors? ____

Diet.

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Beverages: ____

Is there anything your child does NOT eat? ____

ill. Social History of Child.

Are both parents living in the home? Yes No

Names and ages of siblings, if any: ____

Pets: ____

Recent Travel: ____

Recent life changes: ____

Does you child attend school? Yes No If yes, what grade? ____________________________

Any concerns about school? ____

Sports/activities: ____

Any particular household stressors your child has witnessed or gone through:

____

____

Anything else you'd like to share?

Parent/Guardian Signature: ____Date: ______________

Left Hand Community Acupuncture

Community Room Suggested Guideline

It is the intention of Left Hand Community Acupuncture to provide acupuncture and other treatment modalities that everyone can afford. **The chart below is intended as *a guideline only***, and we understand that everyone's situation is unique. Please take into consideration your frequency and length of treatment when choosing your rate, and remember that you can change the amount as needed during the course of treatment.

Annual Income	Treatment Fee
$60,000 & Up	$45
$50,000 - $60,000	$40
$40,000 - $50,000	$35
$30,000 - $40,000	$30
$20,000 - $30,000	$25
Under $20,000	$20

Private Room Treatment Fee: $60 (flat fee)

Initial consultation and Treatment: A one-time fee of $15 is added to the initial appointment, plus cost of treatment.

Insurance: In order to keep our treatment fees low and affordable, we do not bill insurance. If you plan to seek reimbursement from your insurance company, please pay the full amount and we will provide you with a superbill for you to submit to your insurance company.

Cancellation Policy

Because treatments are by appointment only and your appointment time is reserved specifically for you, we request that you acknowledge and respect our cancellation policy. If you need to cancel or reschedule an appointment, please do so **at least 24 hours before your appointment time** by calling our office at 720-248-8626. If we are unable to answer, please leave a message. Patients who do not honor their appointment time will be charged a cancellation fee as follows:

Cancellation with more than 24-hours notice: no charge
Cancellation with less than 24-hours notice or failure to show: $25

We ask for a commitment from you to be here when you are scheduled. Being late for your appointment can disrupt the flow of that day's schedule and so we ask that you please arrive on time. If you arrive later than 15 minutes after your scheduled appointment, your treatment may be forfeited at the discretion of the practitioner and our cancellation policy and associated fees will apply.

Financial Policy

- Payment is expected at time of service by cash, check or credit card. Our sliding scale and private room fees apply to all payments made the day of service, if payments are made after the date of service we reserve the right to bill $120 per treatment.
- The patient agrees to pay all banking fees associated with returned checks.
- No refunds will be given for services already rendered. If you have paid for a treatment package in full and decide to discontinue treatment, you will be refunded for unused services less a 20% processing fee.

I have read and understand the above fee schedule, cancellation, and financial policies.

____________________________________ ____________________

Parent/Guardian Signature Date